OFFICE OF THE INSPECTOR GENERAL

DMHMRSAS

SNAPSHOT INSPECTION

EASTERN STATE HOSPITAL

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INSPECTOR GENERAL

OIG REPORT # 53-02

EXECUTIVE SUMMARY

A Snapshot Inspection was conducted at Eastern State Hospital (ESH) in Williamsburg, Virginia January 9 - 10, 2002. The purpose of this unannounced visit was to review the status of the facility in three essential areas pertinent to basic quality of care issues: the general condition of the facility, the therapeutic activities of the patients and staffing patterns and concerns. The area of focus for this snapshot inspection was the portion of ESH that is dedicated to the treatment of mentally ill geriatric patients, the Hancock Geriatric Treatment Center (HGTC). The team of reviewers consisted of members of the OIG staff and a clinical consultant.

Overall, HGTC was noted to be clean and comfortable with evidence of efforts to make the environment appear less institutional.

Eastern State hospital has been experiencing recruitment and retention problems among nursing staff for a number of years and administration has developed a variety of plans to ameliorate the situation. During the inspection, the team noted that the units inspected had staffing patterns, which were minimal at best. The majority of staff interviewed

identified feeling increasingly stressed due to the persistent use of mandatory overtime to meet minimal staff to patient ratios.

Active treatment opportunities were observed for the higher functioning geriatric patients. Active treatment or other scheduled activities for the lower functioning individuals were minimal. The activities observed by OIG staff did not occur as described in the patient's treatment plan. They either did not occur or were significantly modified in terms of duration.

Facility: Eastern State Hospital

Williamsburg, Virginia

Type of Inspection: Unannounced Snapshot

Date: January 9-10, 2002

Reviewers: Anita Everett, MD

Cathy Hill, M.Ed.

Heather Glissman, B.A.

Laura Stewart, LCSW

Purpose of the Inspection: To obtain information regarding the general condition of the facility, staffing patterns and activities of the patients.

Sources of Information: Interviews were conducted with numerous staff and patients. Random record review occurred. Tour of the Hancock Geriatric Center.

Areas of Review: Section One/General Conditions. Section Two/Patient Activities and Active Treatment. Section Three/Staffing Patterns.

GENERAL INFORMATION

The Hancock Geriatric Treatment Center (HGTC) on the grounds of Eastern State Hospital (ESH) is one of three mental health facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), which serves the geriatric mentally ill population. The other two facilities that provide services to the geriatric population are Piedmont Geriatric Hospital in Burkeville and Catawba Hospital in Catawba.

ESH has an operating capacity of approximately 520 patients. On the last day of the inspection, there was a census of 521 facility-wide; 221 of which were being served in HGTC.

ESH has been serving geriatric persons since its onset approximately 250 years ago. During the 1950's, ESH provided for geriatric services in Buildings 2, 25 and 28. During the next few decades, the census of the hospital grew dramatically to its maximum census of about 3500 patients. A movement occurred during the late 60's and early 70's to have geriatric care occur in free-standing facilities. In keeping with this direction of services, the current configuration of buildings was identified as the Hancock Geriatric Treatment Center in 1976. Since its designation as a separate Center within the operational capacity of ESH, the census of HGTC has remained stable.

SECTION ONE

GENERAL CONDITIONS

Finding 1.1: Overall the physical environment of the Hancock Center was clean and comfortable, with evidence that effort has been made to decrease the institutional appearance.

Background: The review team toured twelve residential and programming wards. The Hancock Center consists of Buildings 32, 34 and 36, which provides for residential and programming areas and Building 33, which contains administrative offices and medical records. The grounds and physical plant were well tended. All of the residential quarters were clean and reasonably comfortable. The bathroom areas were clean and free of odors. Efforts at making this very institutional setting more home-like and comfortable were noted. Among these efforts were private areas were available for family visits which were decorated with curtains, flowers and carpet and pictures. There are central dayroom areas adjacent to the nurses' stations in each ward. Patients were observed to spend most of their waking hours, including meals and activities, in this area. The common areas provide an adequate number of comfortable chairs. These areas were also decorated with pictures and flowers. Ward temperatures were appropriate and comfortable for the population served and the season. The patients were clean and appropriately dressed.

The majority of the sleeping quarters are divided into two to four bed "socials". Three nurses interviewed indicated that the design of the unit allows for maximum observation across the bed areas because of the half-walls or "pony" walls. They recognized that this does not provide for the optimal level of privacy but does enable them to provide closer supervision of patients. As a majority of patients reportedly prefer to be in their beds if not engaged in other activities, nurses related they were able to monitor each person while being able to complete other tasks. Curtains are available around each bed and can be drawn for privacy. Although these areas are very open because of the half-walls efforts to make them more personalized were noted, such as matching bed sets, lamps and rugs.

Recommendation: Continue to promote efforts that result in softening and personalization of this harsh institutional setting.

SECTION TWO

PATIENT ACTIVITY AND ACTIVE TREATMENT

Finding 2.1: The GAP (Geri-Active Program) is designed to meet the active treatment needs of the higher functioning geriatric patient.

Background: There are several distinct program components for the geriatric population at this facility. Each provides for treatment based upon the patient's clinical needs as determined by a multidisciplinary treatment team. Patients are placed within a given program based on diagnostic criteria, degree of cognitive impairment, medical fragility and/or complications, levels of self-help skills, ambulation and other measures of functioning.

Although staff uses the term GAP when referring to the overall active treatment program options for the entire geriatric population, interviews with a supervisor of the program and three active treatment staff revealed that the centralized, structured and comprehensive active treatment program is primarily targeted for higher functioning individuals. The I-GAP groups run Monday through Friday from 9:30 – 11:10 and encompass two sessions with three choices per session. These patients leave their wards to participate in a variety of activities such as music therapy, current events, and motor skills enhancement groups. The broad goal for this program is to enhance skill sets for the patients as well as to prevent the loss of an individual's current level of functioning.

During the inspection it was determined that the majority of patients participating in the centralized program are residents from the acute admissions units housed in Building 32. Of the 200 patients served by the Hancock Center, approximately 30 are regularly served by the GAP program.

Recommendation: The GAP program offers a variety of active treatment options for the minority of higher functioning geriatric patients. Administrative and clinical leaders must seriously re-evaluate the mission and model for active treatment for the remaining geriatric population at ESH.

Finding 2.2: Active therapeutic treatment options for lower functioning geriatric patients were minimal.

Background: A member of the inspection team interviewed six staff and observed three of the scheduled ward based activities. The team member was following the posted schedule of planned afternoon activities for the units. The forty-five minute walking program identified on the master schedule was reportedly completed by the time the team arrived and was reported to have lasted only fifteen minutes. This was attributed to "lack of interest by the patients and limited staffing". A sensory-stimulation group consisted of a staff member working individually with approximately 19 patients in the dayroom area. The therapist was using lotion as the stimulus while engaging in conversation and orientation activities with each individual. Although each person seemed to respond to this interaction one at a time, the total time for each individual was limited to less than two minutes, resulting in all the others sitting unengaged for approximately 43 minutes of the group time. The third scheduled activity, music therapy, did not occur as planned because of a reported lack of interest by the patients. Staff opted to show a movie instead.

The reported number of active treatment hours for each of these individuals is somewhat misleading since the time of their "participation" does not equal the time spent conducting the group activity.

Recommendation: A review of active treatment activities for lower functioning patients is warranted in order to provide effective and appropriate options for this population.

Finding 2.3: Late afternoon and early evening activities in Building 34 were not taking place as scheduled.

Background: Three staff interviewed and observation of the units revealed that the scheduled activities were not occurring. Staff explained that evening programming varies depending on the availability of recreational or occupational therapy staff. Staff members report that with limited numbers of direct care staff activities beyond the physical care of the patients, such as feeding and toileting, are difficult or near impossible to perform. On one unit in Building 34, the staff was not able to locate the program schedule and did not have any idea if active treatment activities were to be offered to the unit's nineteen patients that afternoon. Patients were observed to be either sitting in the dayroom or resting in their beds.

Recommendation: **A review of active treatment activities for lower functioning patients is warranted in order to provide effective and appropriate options for this population.**

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Finding 2.4: Records reviewed reflected limited documentation linking treatment needs to discharge readiness and the justification for continued hospitalization.

Background: Nine records were reviewed during the course of the inspection. In seven of those, the barriers to discharge as outlined in the progress notes were not addressed in the treatment plans. Discharge notes were inconsistently written but in eight of the records usually appeared once a quarter. A review team member was also able to briefly sit in on a treatment planning session. While the team represented all disciplines, and the staff, within their respective roles, appeared knowledgeable about the patients, there was an unfortunate overemphasis on the completion of forms. This was partly explained to be the result of the Center's effort to streamline these functions by converting to a new system, which should improve the efficiency of the treatment conference. However, this seemed to preclude a really interactive or synergistic clinical discussion of the patients, their responses to treatment, and their needs.

Recommendation: Promote better utilization of the clinical talent participating in the treatment planning conferences. Improve concentration by the teams on issues related to preparation of patients for discharge, as evidenced in the records.

SECTION THREE

STAFFING PATTERNS

Finding 3.1: Staffing shortages are critical for nursing services in the Hancock Center.

Background: Eastern State hospital has been experiencing recruitment and retention problems among nursing staff for a number of years and administration has targeted a variety of solutions to ameliorate the situation. However, it was evident from the tour of all the units in the Hancock Center and twenty-six staff interviews, both structured and less formal, on the two days of the inspection, that while the minimum required numbers of staff were present on each unit, the morale, fatigue and frustration of direct care staff is at a critical stage. This has been the case during previous inspections conducted by the OIG in the adult treatment buildings on the ESH campus as well.

The dissatisfaction was identified by all staff as stemming from high levels of mandatory overtime, and the sense that there was no equitable system in place for outlining and managing overtime. All staff indicated that it is often difficult to arrange to have the scheduled meal break much less have adequate coverage in the event of a crisis or demand on the unit. Six staff interviewed indicated that favoritism was used when managing overtime schedules.

OIG staff observed during the tour, both in the afternoon and evening, that it was common for the dayroom area, where the majority of patients were located, to have no staff supervision. Building 32 did not have an RN on each unit during the evening. There was an RN in a floater position and she rotated among the wards as needed. It was very difficult to find opportunities to interview staff because of the shortages. Nursing staff were engaged in providing basic patient care. This prohibits the provision of active patient treatment. Observations of most of the units and the activities provided were more akin to nursing home care than that of a psychiatric facility.

Recommendation: Administrative and clinical leaders must seriously re-evaluate the mission and model for the goals of serving the geriatric population. Increase staffing levels as needed for active, effective patient treatment rather than basic patient care if this is determined to be the treatment goal for the Hancock Center.